STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395567	A. BLDG: 00 B. WING:	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
DUNMORE HEALTH CARE CENTER STATE LICENSE NUMBER: **120902**	**1000 MILL STREET** **DUNMORE, PA 18512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Abbreviated Complaint Survey completed on January 24, 2025, it was determined that Dunmore Health Care Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0658 SS=D		F 0658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0658 SS=D	Continued from page 1 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Resident #1 no longer resides at the community. Employee #2 provided 1:1 education on resident assessment post change in condition by the DON/Designee. To identify like residents that have the potential to be affected the DON/Designee conducted a 2 week look back of nursing progress notes and 24 hour reports to validate that a thorough and timely nursing assessment conducted post change in condition.	Completion Date: **02/06/2025** Status: **APPROVED** Date: **02/05/2025**

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F 0658 SS=D	Continued from page 2	F 0658	To prevent this from happening again the DON / Designee will educate the licensed nurses on recognizing and intervening in the event of change in resident condition. The registered nurse will be educated on conducting and documenting a timely assessment and follow-up when change in condition identified. The education will be completed by 2-6-25 To prevent this from happening again the Regional Nurse will educate the Interdisciplinary team on reviewing changes in condition at morning meeting to ensure compliance. The education will be completed by 2-6-25. To monitor and maintain ongoing compliance the DON / Designee will conduct an audit of 5 residents with changes in condition per week for 4 weeks then monthly for 2 months to ensure professional standard of practice and timely follow-up. Results of audits will be submitted to the QAPI committee for further review and recommendation.	

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F 0658 SS=D	Continued from page 3 Based on review of clinical records, select resident incident report, and staff interviews it was determined the facility failed to provide nursing services consistent with professional standards of quality by failing to thoroughly conduct and document the results of a professional nursing assessment regarding the clinical status of a resident following a change in condition for one resident (Resident 1) out of 8 residents reviewed. Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient ' s EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: · Assessments	F 0658		

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F 0658 SS=D	Continued from page 4 · Clinical problems · Communications with other health care professionals regarding the patient · Communication with and education of the patient, family, and the patient's designated support person and other third parties. A review of Resident 1's clinical record revealed an admission date to the facility December 5, 2018, with diagnoses to include aphasia (a language disorder that affects the ability to speak and understand what others say. It usually happens suddenly after a stroke or traumatic brain injury). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated November 7, 2024, revealed that Resident 1 was cognitively impaired and required substantial assistance with activities of daily living.	F 0658		

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F 0658 SS=D	Continued from page 5 A review of nursing documentation dated September 10, 2024, at 7:38 p.m., revealed Resident 1's daughter expressed concern about her mother's condition to Employee 1 (LPN). Employee 1 noted the resident was clammy, and lethargic. Resident 1's vital signs were taken and her Oxygen saturation (the amount of oxygen you have circulating in your blood) was 87%. The normal range is 95 to 100%. Resident 1's daughter asked the RN supervisor on duty Employee 2, to assess her mother. The resident's nursing progress note stated that Employee 2 was present on unit to assess the resident. However, there was no documented evidence that an assessment was completed. Further review of the clinical record revealed no additional documentation regarding Resident 1's condition until September 11, 2024, at 9:10 a.m., when Employee 3 (RN) noted the resident's condition had not improved and contacted the physician. STAT (immediate) labs were ordered, and results returned at 11:53 a.m. indicated an	F 0658		

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F 0658 SS=D	Continued from page 6 elevated white blood cell count of 32.68 K/ul (thousands per microliter of blood normal adult 4.0 K/ul -11.0 K/ul or 4000-11000 cells per microliter), consistent with an active infection. However, the resident was not transferred to the hospital until 2:01 p.m. on September 11, 2024. Resident 1 was later diagnosed and treated for sepsis (a condition that arises when the body's response to infection causes injury to its own tissues and organs) returning to the facility on September 17, 2024. There was no documented evidence that a thorough and timely nursing assessment was conducted following the resident's initial change in condition. Additionally, the facility failed to escalate care in a timely manner, which delayed appropriate medical intervention. The facility failed to ensure nursing services were provided consistent with professional standards. Interview with the Nursing Home Administrator and Director of Nursing on January 24, 2025, at 11:30	F 0658		

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F 0658 SS=D	Continued from page 7 a.m. confirmed that the facility nursing staff didn't timely assess and timely send the resident to the hospital for her documented change in condition resulting in the lack of provided nursing services consistent with professional standards.. 28 Pa Code 211.12 (1)(3)(5) Nursing Services	F 0658		

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P 5520		P 5520		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility cannot retroactively correct the past C.N.A Ratios Moving forward, the facility will continue to make good faith effort to schedule staff to meet or exceed the mandated ratios of One NA to 10 residents on day shift; one NA to 11 residents on evening shift and one NA to 15 residents on night shift. The facility will make all good-faith efforts to utilize both internal and external resources to meet or exceed the staffing ratios. The facility contracts with agencies to supply aides to meet requirements but call offs and no-show result in unmet ratios. The facility is working to hire and train staff to achieve the minimum staffing ratios for nurse aides. The facility offers bonuses to staff to encourage staff to pick up additional shifts. To prevent this from reoccurring, the RDCS re-educated the NHA, DON	Completion Date: **02/06/2025** Status: **APPROVED** Date: **02/05/2025**

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P 5520	Continued from page 2	P 5520	and Scheduler on the updated staffing regulations in relation to the minimum ratio of one NA to 10 residents on days, one NA to 11 residents on evenings and one NA to 15 residents on nights.. The staffing is reviewed each day for the subsequent day(s) by the NHA and/or DON to ensure adequate staff to meet or exceed the minimum ratios. Needs are posted each week for internal staff to pick up extra shifts as well as posted with outside agencies. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds the minimum NA ratios. Audits will be completed 5x weekly x4 weeks; 3x weekly x1 month and weekly x1 month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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P 5520	Continued from page 3 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for two shifts out of 21 reviewed. Findings include: A review of the facility's weekly staffing records revealed on the following dates the facility failed to provide minimum nurse aide staff of 1:10 on the day shift, 1:11 on the evening shift, and 1:15 on the night shift based on the facility's census. January 19, 2025 - 5.07 nurse aides on the night shift, versus the required 5.67 for a census of 85. January 21, 2025 - 7.07 nurse aides on the night shift, versus the required 7.73 for a census of 85. On the above dates mentioned, no additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 4 An interview with the Nursing Home Administrator on January 24, 2025, at approximately 2:00 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 5 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility cannot retroactively correct the past LPN Ratios Moving forward, the facility will continue to make good faith effort to schedule staff to meet or exceed the mandated ratios of One LPN to 25 residents on day shift; one LPN to 30 residents on evening shift and one LPN to 40 residents on night shift. The facility will make all good-faith efforts to utilize both internal and external resources to meet or exceed the staffing ratios. The facility contracts with agencies to supply LPN's to meet requirements but call offs and no-shows result in unmet ratios. The facility is working to hire and train staff to achieve the minimum staffing ratios for LPN's. The facility offers bonuses to staff to encourage staff to pick up additional shifts. To prevent this from reoccurring, the RDCS re-educated the NHA, DON and Scheduler on the updated staffing regulations in relation to the minimum ratio of one LPN to 25	Completion Date: **02/06/2025** Status: **APPROVED** Date: **02/05/2025**

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P 5530	Continued from page 6	P 5530	residents on days, one LPN to 25 residents on evenings and one LPN to 40 residents on nights.. The staffing is reviewed each day for the subsequent day(s) by the NHA and/or DON to ensure adequate staff to meet or exceed the minimum ratios. Needs are posted each week for internal staff to pick up extra shifts as well as posted with outside agencies. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds the minimum NA ratios. Audits will be completed 5x weekly x4 weeks; 3x weekly x1 month and weekly x1 month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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P 5530	Continued from page 7 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for 1 shifts out of 21 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:25 on the day shift; 1:30 on the evening shift; and 1:40 on the night shift. January 21, 2025 - 2.00 LPNs on the night shift, versus the required 2.13 for a census of 101. On the above dates mentioned, no additional excess higher-level staff were available to compensate this deficiency. An interview with the Nursing Home Administrator on January 24, 2025, at approximately 12:00 PM,	P 5530		

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P 5530	Continued from page 8 confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		
P 5640		P 5640		

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P 5640	Continued from page 9 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility cannot retroactively correct the staffing PPD issues. The facility utilizes staffing agencies, bonuses for staff and actively recruiting for new staff. Management staff is utilized to achieve mandated staffing requirements. To prevent this from reoccurring, the RDCS re-educated the NHA, DON and Scheduler on the updated staffing regulations in relation to the daily PPD of 3.2 hours. The staffing is reviewed each day for the subsequent day(s) by the NHA and/or DON to ensure adequate staff to meet or exceed the minimum PPD. Needs are posted each week for internal staff to pick up extra shifts as well as posted with outside agencies. The deployment sheets are developed in advance so staffing challenges can be addressed. A good faith effort is made to achieve the mandated staffing requirements. Supervisors are educated on the importance of filling call offs to meet	Completion Date: **02/06/2025** Status: **APPROVED** Date: **02/05/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395567	A. BLDG: __00_____ B. WING: _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
DUNMORE HEALTH CARE CENTER STATE LICENSE NUMBER: **120902**	**1000 MILL STREET DUNMORE, PA 18512**

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P 5640	Continued from page 10	P 5640	requirements. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds the minimum PPD. Audits will be completed 5x weekly x4 weeks; 3x weekly x1 month and weekly x1 month. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395567	A. BLDG: 00 B. WING:	01/24/2025

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P 5640	Continued from page 11 Based on a review of nurse staffing, state regulation, and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily. Findings include: A review of the facility's staffing levels revealed on the following dates the facility failed to provide minimum nurse staffing of 3.20 hours of general nursing care to each resident: January 19, 2025 - 3.09 direct care nursing hours per resident. January 21, 2025 - 3.05 direct care nursing hours per resident. January 22, 2025 - 3.10 direct care nursing hours per resident. The facility's general nursing hours were below minimum required levels on the dates noted above.	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 12 An interview with the Nursing Home Administrator on January 24, 2025, at approximately 2:00 PM, confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily.	P 5640		

Certified End Page

DUNMORE HEALTH CARE CENTER

STATE LICENSE NUMBER: 120902

SURVEY EXIT DATE: 01/24/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY